HOSPITAL EFFICIENCY

WILLIAM H. ALLEN, PH.D.
General Agent, The New York Association for Improving the Condition of the Poor

"Hospitals must not only know themselves what each item of service costs, but they must show the public that they know, and they must enable the public also to know. It is our judgment that the hospitals themselves have it in their power, by moving along this line, to tap sources of popular support that will be adequate to any need."

These are not the words of carping critics, dreaming theorists, "statistical fiends," nor the superficial judgment of men with only a passing interest in hospital needs. On the contrary, they are two sentences from the final report to the hospitals of Greater New York by a committee[1] appointed March 23, 1905, by a conference of over twoscore hospitals, to consider means of increasing hospital support.

For months the hospitals of New York City had been advertising deficits of from $1,000 to $9,000 aggregating nearly $750,000; for lack of funds, wards were being closed, out-patient work curtailed or postponed, obvious needs neglected; charges of extravagance and abuse were given wholesale currency, even though emanating from untrustworthy sources; certain physicians who were denied the privilege of practicing in hospitals attributed deficit and censure to the monopoly enjoyed by certain other physicians charged with running the hospitals for the benefit of

[1] Committee on Hospital Needs and Hospital Finances: chairman, John E. Parsons, president of General Memorial and Woman's Hospitals; John Winters Brannan, M.D., president of Bellevue and Allied Hospitals; T. O. Callender, representing Brooklyn hospitals; Professor Frederick A. Cleveland, expert on finance; ex-Mayor Seth Low; Hoffman Miller, secretary of St. Luke's Hospital; Thomas N. Mulry, representing Roman Catholic hospitals; Leonard E. Opdycke, Sea Breeze Hospital; Frederick Sturges, president of the Hospital for the Ruptured and Crippled; Frank Tucker, finance expert; John A. Wyeth, M.D., president of the Polyclinic Hospital; secretary, William H. Allen, general agent of the New York Association for Improving the Condition of the Poor.

their private practice; one newspaper attack followed another, editorial strictures supporting letters and interviews with patients and contributors. Instead of the convincing reply that the beneficent work of the hospitals justified, there was silent disdain, reference to the respectability and self-sacrifice of hospital managers, or appeals for more funds. Hospital reports lacked uniformity and clearness as to receipts and expenses, hence threw little light upon the real situation, and furnished shaky ground for meeting public criticism. One writer, exasperated by the hospitals' supine helplessness, asked: "If these hospitals have right on their side, why do they not show it?"

To divert the attention of press and contributor from minor defects to inestimable service and urgent need, a conference was called by the New York Association for Improving the Condition of the Poor, on the ground that the city's poor suffer most from hospital deficits. Over forty hospitals were officially represented by managers, superintendents, and auxiliary committees. In addition were delegates from relief societies, dispensaries, churches, and social settlements. The published programme directed discussion to the following methods that various hospital presidents had suggested for improving the financial condition of private hospitals:

To increase revenues.—Educate the public to give more; arouse the public by personal rather than formal appeals; induce pastors of all denominations to speak more freely and more frequently of giving; strengthen the central appealing body; create for each hospital a roll of regular annual contributors; let the city increase the rate for free patients; undertake by common action to raise an adequate endowment.

To decrease expenditures.—Secure future enlargement of facilities through inexpensive house-to-house treatment rather than through additional hospitals or additional wards; prove that present revenues are economically expended; find out how much hospital work ought to cost, and keep within the standard.

To make information available.—Exchange freely experiences as to expenses and revenues.

Before adjourning, the conference asked its chairman to ap-

point a committee to consider hospital needs and hospital finances. This committee of hospital officers, contributors, finance experts, worked for fifteen months; studied the hospital experience of American and European cities; submitted in November, 1905, tentative suggestions as to practicable economies, accounting, and support that elicited helpful comment from a large number of hospital officers and physicians; and finally, June 1, 1906, recommended unanimously but one remedy for deficits, extravagance, obsolete methods, or lack of public interest—*more light.*

Many managers looked askance at the proposed remedy—viz.: uniform, up-to-date system of accounts and reports. "What! remove a deficit by expending more money on statistics?" One manager condensed into a paradox the doubt, and opposition, and fatalism that pervaded many boards: "Few hospitals can afford to keep competent bookkeepers." Fortunately, there were other hospital managers able to answer from their own hospital experience: *"No hospital is rich enough to afford an incompetent bookkeeper;" "No hospital is too poor to afford proof that it is run on an economical basis consistent with efficiency in treatment;" "No hospital is too poor to spend* $5 *in saving* $10 *or in making out a case that will secure a gift of* $100;" *"The methods and needs of our hospitals are misunderstood. The only way to remove misunderstanding is to produce understanding."* The arguments for more light gained weight from the fact that managers were willing to admit the extravagant tendencies of physicians who "seem to think that materials do not cost anything," and that their "gratuitous service gives them license to throw economy to the winds." During the discussion physicians of high rank in several hospitals admitted that they used two, four, or eight times the material in hospitals that they did in their private practice, and vied with each other in telling stories of mismanagement. The defense of such volunteer supervision as is possible where there is no proper accounting was answered by a hospital president: "Our American system is all right from the point of view of training physicians and nurses, but all wrong from the point of view of hospital management."

Managers who feared that more light would cost too much, or

would lead to unfair comparison, were told by others of savings and earnings effected by improved accounting: "cost of fence reduced 50 per cent.;" "saving of coal, $6,000;" "$150 a week on linen bandages alone;" "13 per cent. saved on provisions by checking storeroom;" "thousands saved on drug bill;" "regained the confidence of our benevolent people, lost because of former extravagance and inability to prove effort to economize."

Editorial comment in medical and hospital journals, as well as in the secular press, showed a general conviction throughout the country that hospitals ought to tell the public more—ought first to want to know more themselves—about the efficiency and economy of their physicians, their superintendents, their nurses, and the managers themselves. "A general impression is gaining ground that the funds invested by a community in social betterment should be more carefully husbanded and more efficiently applied." "If a dozen hospitals should unite in submitting themselves to professional advice regarding their accounts, and should publish such certification of methods and results, every presumption would favor those so acting in comparison with those neglecting such simple means of fortifying themselves in public esteem." "Where there is no accounting, there is no responsibility and no contentment." "Managers should maintain their positions, not because they are estimable gentlemen, but because of their efficiency in the performance of the duties they are expected to perform."

It is made extremely difficult to discuss the efficiency of volunteer hospital boards, because their service is voluntary, and because it is true that hospitals managed by them have been more efficient, as a rule, than hospitals managed by paid (political) superintendents. It is intended to contrast here, not a noble-minded philanthropist with a political appointee, a well-managed private hospital with a badly managed public office; but rather is it hoped to indicate that among philanthropists and political appointees the main distinguishing difference of value is not salary or no salary, or moral character, but efficiency.

The reluctance to adopt at once the remedy *more light* is traceable partly to inertia, partly to the goodness fallacy, and

partly to the estimable-gentlemen-men-of-affairs tradition in hospital management. What more should the public need to know than that "hospital boards are under the direction of managers recruited by natural selection from our best citizens?" To challenge the efficiency of these naturally (mutually) selected best citizens, to insinuate that any shortcomings could offset their benevolent inattention, or gratuitous and self-sacrificing service, seems almost ungrateful. Are not hospital boards made up mainly of men who have won great success in their own business, "men to whom you would gladly intrust your fortune for investment"? It certainly seems strange that a man who has been able in law or business to gain foremost rank in his community should not be thoroughly efficient in managing a small affair like a hospital. If you add to this man's business prowess that of his fifteen fellow-directors, you have, indeed, a strong combination of intelligence, and interest, and efficiency. They give lavishly of experience, judgment, time, and study that in the world of commerce would be worth thousands and hundreds of thousands of dollars. Is not, therefore, the mere suggestion of inefficiency in their management of hospitals an indictment of their own business integrity or acumen?

Fortunately it is not. The successful lawyer does not expect every man he meets to approve his golf-playing, or his singing, or his choice of ties. To say that a man swims badly, is a poor tennis player, talks too much, laughs too often, jokes too freely, works too hard, is never accepted as an indictment of his business ability. Few bankers or lawyers would accept responsibility for the successful management, during their spare hours, of a department store or a theater. But for some reason the man who knows the stock market from *A* to *Z* expects his colleagues and the world at large to believe that because he is a director he must know from *A* to *Z* the business of running a hospital, school, charitable society, or church. It is not sufficiently appreciated that this lawyer, or broker, or merchant is applying entirely different methods and tests in his hospital work—methods that would wreck his own business and lose him every client over night. Men whose affairs are organized on the principle that a

$100 clerk should never be permitted to do the work of a $30 messenger will go into a hospital and spend their time on routine inspection, making estimates, counting details. The serious aspect of this situation is not so much that the directors' energy is wasted, as that the work itself is poorly done. Because many directors do not apply the efficiency test to their own connection with hospital management, or because so many have a false and misleading standard of trusteeship, false and misleading standards are applied to the work of the various departments of a particular hospital, to the hospital as a whole, and to all of the hospitals in a community viewed as one group that ought to be disclosing and attacking the conditions that make for sickness and depleted vitality.

The director has a ticker in his office, showing changes of the market; keeps a double-entry set of books with indexes galore to enable him to tell instantly where his business stands today as compared with yesterday and the day before, and never dreams of trusting the memory of a clerk or a colleague as to the result of the year's business. So eager is the efficient business man to learn from his own mistakes and from the success of his competitors that patents and copyrights are granted to protect initiative and originality. Yet this same efficient business man metamorphosed into recognized success as director loses his avidity; governs the hospital without analyzing his own and his colleagues' experience; accepts from a hospital superintendent or treasurer a summary of the year's work that does not show where the hospital stood at the beginning of the year, how far it has traveled, what direction it is going, what needs it has met, what needs it has failed to meet. He feels toward himself and associates as one hospital president felt toward his superintendent: "It is enough for me to know that Mr. X is there.

Mr. A is officer of two hospitals. He would be unwilling to say that he is more interested in one than in the other; that he has been more intelligent or more efficient in one than in the other. Hospital A is successful, hospital B is unsuccessful in securing donations, though the work of the latter has the stronger appealing power. Hospital A is celebrated for its efficient management;

hospital B has not the same reputation; in fact, it is not long since serious difficulties, involving both waste and infidelity, were discovered. What is the difference? It just happens that in hospital A there is an up-to-date mechanism for applying the efficiency test to the work of every department and of every officer, including the directors themselves; in hospital B there is no such test. The difference is not due to the character of the trustees, for in hospital A, prior to the adoption of the statistical method, the same conditions existed as in hospital B.

A similar discrepancy exists in the case of another prominent officer of hospital B, who happens also to be officer of a charitable institution that always obtains support and—is it by chance?—uses methods that would be creditable to a railroad.

A superintendent who is not able to control the dietary of his hospital maintains that the waste would support a ward of forty beds. Another says that "barrels of good food" are thrown away every day. A celebrated surgeon admits that for every towel used by him in private practice he uses eight when operating in a hospital. Another surgeon recently ordered instruments costing $500; he had checked from a catalogue all the things that he thought would be "nice" to have. An officer of a hospital that protests indignantly against the insinuation that its business methods need revision, visited a western hospital and now regales his friends with the story of how "the ideas I brought back with me save thousands of dollars annually for my hospital." A secretary becomes interested in the drug supply, and by insisting upon a monthly report saves enough to maintain one ward. A ventilating apparatus, costing enough to build a ward, is found too late to be extravagant. One storeroom saves $150 a week on linen bandages without the surgeons having noticed any reduction in the supply. Even conservative directors protest against the G. P. fetish—the domination of the grateful patient whose generosity imposes costly burdens.

That such things should occur in hospitals is not at all surprising, and is not at all occasion for criticism; but for them to exist without being detected by the directors or superintendents, or by a prospective giver wishing to make sure that his gift will

be well invested, is reason for disquietude. On my desk are a number of hospital reports. In one a giver can find the number, age, and sex of cases treated, and whether care was given in the hospital or at home, for sixty-two different diseases; all about operations on one hundred different parts of the body; number cured, improved, unimproved. and died. Of expense he finds just one item: "hospital expenditures, $100,000." Not a word as to how the money was spent; how the total compares with last year; what work it was impossible to do; what new needs were disclosed; how much went for care of the buildings; how much for care of patients, for annual report, etc. The giver has learned, however, that a considerable percentage of the cost was met by consuming endowment. Scores of millions and unsurpassed executive ability are represented on the board of managers, whose principal officers happen also to be officers of other societies that publish excellent reports.

The second report gives nearly one hundred pages to tabulation of details regarding every conceivable disease; the dietary is given; in the list of contributions in kind are cut flowers, ice, crockery, toys, and magazines. But nowhere does this report show the number of beds; what it costs to maintain a bed in the surgical department, in the general ward, or in the babies' ward; or the cost of kitchen or laboratory. It does not explain how beds may be endowed in perpetuity for $5,000, yielding $225 annually, when it costs four times that sum to keep a patient in that bed. One cannot learn what proportion of provisions went to the attendants, who number 30 per cent. more per day than patients; what it costs to keep a private patient; how much money the hospital needs next year; the total of the endowment fund; what efforts were made to obtain from current donations enough to keep the hospital open eighteen out of 365 days. There is no asset or liability account, no showing of work done and funds disbursed in the different months. Yet this hospital is widely known for its excellent service, as well as for its deficits and closed wards.

Two other reports tell all about fasciotomies, carcinoma, ventriculi, as well as nationality and dress of patients, distribution of provisions, etc.; but neither tells how much it costs to support a

patient a day or a week; what endowment is required to pay the entire expense of supporting a bed in perpetuity; what proportion of maintaining the cost of free beds is borne by public subsidy; what fraction of the day's treatment given is wholly free; how much certain or pledged income the hospital has. Not one summarizes the facts published so as to show the direction in which it is going with respect to classes of patient or of expense. Yet these reports are vastly superior to the average hospital report, and the hospitals for which they plead are among the foremost of their kind in the world. Each reports current expenses in excess of current income by many thousands of dollars. Each consumes endowment and legacy, whereas it is supposed to use only the interest on those funds. In this respect, too, they are typical of private hospitals throughout the world.

For the Hospital Conference above referred to a comparative digest was prepared, showing, so far as was possible from the reports of twenty-six general hospitals, fifteen special hospitals, and ten women's and children's hospitals, what degree of uniformity existed as to 120 items. This number, 120, consists of facts that one hospital or another found it of importance to record. Many of them failed to give even the total patient beds, few even the percentage of free days and the endowed bed days; several of the important hospitals did not give even the number of patients; only a half-dozen gave the largest number of patients at one time, and not half the average number of patients per day; eleven of the fifty-one gave the gross cost per patient per day, one the cost of food per patient per day; five, the number of days' board given employees; two, the cost of private patients. A half-dozen analyzed receipts to show the relative importance of different sources of income. Few broke up the item of income into its component parts to show of contributions how much was due to donations, membership dues, subscriptions, entertainments and fairs, church collection boxes, auxiliary collections; how much of hospital receipts came from ward patients, private-room patients, special nursing, board of non-patients, use of operating-room, etc.; of dispensary receipts, how much from fees, and sales of drugs; how much from ambulance, or from out patients for services and supplies;

how much from the city or from the Saturday and Sunday Hospital Association; how much of permanent investment was wiped out for current uses.

But, however detailed and satisfactory the report of any individual hospital, it can tell but part of its story unless given in the same language as that of other hospitals doing similar work. It is said that we learn most by imitation. At least it is true that we learn much by observing our colleagues, whether in the factory doing piece work, in the shop buying silk, in business selling goods, or as trustees administering a hospital. Having learned what we can by examining carefully our own hospitals, it is important to learn whether or not our house physician, our superintendent, our building, our situation are bringing results comparable with those of hospitals that appeal to the same public to support the same kind of work.

Entirely apart from the importance of learning how to reduce expenditure so as to keep pace with the best thought in the hospital world, it is also necessary to be able to explain differences in expense, showing that they are due to differences in kind of work or in quality of material rather than in spirit or practice of economy. An Italian patient coming to a hospital is helped if he can speak English, or if there is an Italian-speaking person in connection with the hospital, or if a friendly Italian happens to be there at the time, or perhaps by signs. In any event, the only way the hospital and the Italian patient can work together to aid that patient is to discover somewhere a common language. Is it not quite as important that ten hospitals discussing their experience should use the same language?

The first step in what bids fair to become a revolution in the attitude of American hospitals toward actual and potential givers was taken in New York in June, 1906, when four of the leading hospitals[2] agreed upon a common form of recording and publishing important facts as to efficiency and needs.

Because this plan furnishes the basis for a publicity campaign in behalf of all American hospitals, and because it is the

[2] New York, Presbyterian, Roosevelt, St. Luke's.

Big Four's response to the agitation of the past two years, it is published here in full.

There is not a hospital in the country that could not describe its experience and its needs in the language provided by the foregoing schedules. Wherever managers want to answer questions not here asked, it is easy to insert a new sub-heading. It is quite conceivable that many managers will not care to distinguish medical from surgical supplies, or milk and cream from butter and eggs; in this case the general headings may still be used and should be used, as should the comparative tables. Uniformity would still exist if hospitals having few patients, needing little public help, and desiring to learn little from their own or others' experience, should put all expenditures under the general heads.

	1905	1906	Inc.	Dec.	Per cent.
Administration expenses.....					
Professional care of patients.....					
Department expenses.....					
General house and property expenses..					
Corporation or other expenses.....					

The cost of making this separation is a trifle, because it is quite as easy to post an expenditure of $10 on one sheet as on another, and infinitely more valuable to have it posted where it answers an important question.

Two additions will undoubtedly be made as time tests this uniform schedule—viz.: a column showing *increase* or *decrease,* and a column for *percentages.* The purpose of reports is to *inform;* the purpose of uniformity is to enable the public to use one language in studying the needs of different hospitals and to enable each hospital to learn from others' experience; the comparison of this year with last shows whether each department of each hospital is going forward or backward, or standing still. But even directors seldom make the actual subtraction necessary to see that $22,418 is $2,545 greater than $19,873. When that is done, still fewer would discover that the increase is 11 per cent. We deem it of great importance to know that a poor family pays 25 per cent. for rent and 45 per cent. for food; it is quite as valid to ask what proportion of hospital income goes directly to pro-

fessional care of patients, and what to central offices. Is it worth while to make sure that every reader has the result of the subtraction and percentage? The benefits would outweigh the cost, if only managers themselves were given truth that does not mislead.

An annual report cannot be prepared without great expense and greater error, unless the record of each day's work is taken with a view to answering the questions propounded in the annual report. As one hospital officer wrote recently: "*Yearly* statistics are only *interesting*. For practical purposes, such as checking extravagancy, locating a leak or loss, discovering inferior supplies, and for locating any new condition that may arise, *monthly* and sometimes *weekly* statistics are necessary." As business men know, weekly and daily blanks may be purchased to order, with instructions for their use, if once a hospital decides what information it will call for from its various officers. Many hospitals are having the experience thus described by an officer of a Worcester, Mass., hospital: "We have on our board two very successful manufacturers who have made a thorough study of reducing expenses in their business. They thought they could apply the same methods to the hospital accounts. They have adopted an entirely new system never before used in any hospital, from which we expect notable results."

The first effect of a uniform system of reporting and accounting will be comparison of two hospitals whose effort is differently distributed among various kinds of work. For example: You read in a comparative statement that Hospital A spends $2.75 a day for each ward patient, where Hospital B spends but $1.90 per day. Without knowing more of the work of these two hospitals, it appears that Hospital A is extravagant. Upon inquiry it may develop that Hospital A has a much larger proportion of cases requiring surgical attention, operation, use of bandages, special diet, extra nursing; whereas most of the work of Hospital B is for protracted diseases requiring little special attention and little extra nursing or diet. Obviously there are two ways of preventing misunderstanding. One is by failing to take part in a plan for uniform accounting for fear that one's hospital will be misrepresented; the

other is to use the same language as the other hospital and explain what seem to be discrepancies. The trouble with the first plan—evasion—is that it does not succeed. An uninformed public is a fickle friend. The Committee on Hospital Needs and Finances strongly recommended that the hospitals of New York combine in making a study of the different hospitals, showing exactly how each one is organized, what work it undertakes, what mechanism it uses to accomplish this result; and then compare hospitals only so far as they are doing a similar work. Such a compendium would work as follows: Two hospital superintendents compare notes. One is using thirty tons of coal a month, the other is using fifty. These facts in themselves tell nothing as to the economy of the first hospital. When we know that they treat exactly the same number of patients, the difference in coal comes to mean a difference either in stoking, in character of building, in method of ventilation or in coal. The superintendent who uses fifty tons a month will want to know how the other's building is constructed, what furnace and what ventilating apparatus are in use, what kind of coal is purchased. If they find that the same apparatus is in use; if the buildings are constructed in practically the same way; if the same quality of coal is used, then there is reason to believe that either his stoker or his engineer is careless in the use of coal; that the coal is pea when it should be buckwheat; that there is theft; that coal fails to reach the bunkers; that his apparatus is out of order; or that *the difference must be explained by the failure of the economical hospital to give its patients proper heat and ventilation.* In any event, to separate each hospital into its component parts makes it possible to arrange eighty hospitals so that each can learn from the others' experience.

In the absence of such compendium, no language exists to express in clearness and fairness the experience of hospitals without misrepresenting one or the other. Some hospitals are small, some isolated, some in congested districts; some exist for surgical cases only, others for maternity cases, some for convalescent rather than acute cases. It is obvious that it is as impossible, without knowing more than the term "hospital," to class together twenty such institutions, as to attempt by the word "man" to bring

within one class twenty men of different nationalities, different ages, different walks of life.

This last year a conference was organized of the New York City hospital superintendents to meet regularly to compare notes as to hospital management. The National Association of Hospital Superintendents has accomplished much in stimulating interest and impressing upon hospitals throughout the country that they have much to learn from each other's experience. The measure of its success, however, as the measure of profit from verbal exchange of experience, is in a published statement shorn of personal elements, putting in black and white points of difference and points of agreement. The hospitals and the public should have an annual digest of hospital data such as that which has helped the British hospitals so much during the past ten years. When this manual is published—an American Burdette—it is to be hoped that it will be adequately supported so as to emphasize over and over again the highest mission of the hospital—to conduct an active, progressive, educational campaign, informing the public regularly and repeatedly as to the causes that make for preventable mortality, sickness, and misery. When the selected men of our communities can tell at a glance what now requires hours of stumbling in committee, their valuable services and business talent will be released for the statesmenlike work they are in position to do. It will not then be necessary for crusades like the tuberculosis crusade to originate outside the hospital, nor for laymen to sound the alarm for impure milk, unsanitary bakeshops, filthy streets, and overcrowded tenements. It will not be true that eighty hospitals spend $4,000,000 without the community's learning anything from their experience to make tomorrow better than today.

SCHEDULE I

DETAILED STATEMENT OF OPERATING, CORPORATION, AND OTHER CURRENT EXPENSES

ADMINISTRATION EXPENSES

	1906	1905
Salaries, officers, and clerks	....	....
Office expenses	....	....
Stationery, printing, and postage	....	....
Telephone and telegraph	....	....
Legal expenses	....	....
Miscellaneous	....	....
Total administration expenses	....	....

SCHEDULE I—*Continued*

PROFESSIONAL CARE OF PATIENTS

	1906	1905
Salaries and wages:		
Physicians		
Superintendent of nurses, assistant, and instructors		
Nurses		
Special nurses		
Orderlies		
Special orderlies		
Ward employees		
Equipment for nurses:		
Uniforms		
Books		
Instruments		
Medical and surgical supplies:		
Apparatus and instruments		
Medical supplies		
Surgical supplies		
Alcohol, liquors, wines, etc		
Dispensary: Salaries and labor		
Supplies		
Emergency ward: Salaries and labor		
Supplies		
Visiting and home (district) nursing: Salaries		
Supplies		
Total professional care of patients		

DEPARTMENT EXPENSES

Ambulance:	Labor		
	Supplies		
Pathological laboratory:	Salaries and labor		
	Supplies		
Training school:	Salaries and labor		
	Supplies		
Housekeeping:	Labor		
	Supplies		
Kitchen:	Labor		
	Supplies		
Laundry:	Labor		
	Supplies		
Steward's department:			
Labor			
Provisions:			
Bread			
Milk and cream			
Groceries			
Butter and eggs			
Fruits and vegetables			
Meat, poultry, and fish			
Total steward's department			
Total department expenses			

GENERAL HOUSE AND PROPERTY EXPENSES

Electric lighting		
Fuel, oil, and waste		
Gas		

SCHEDULE I—*Continued*

	1906	1905
Ice		
Insurance		
Maintenance, real estate and buildings		
Maintenance, machinery and tools		
Plumbing and steam-fitting		
Photography		
Rent		
Miscellaneous		
Total general house and property expenses		
Total operating expenses		
CORPORATION OR OTHER CURRENT EXPENSES		
Salaries, officers and clerks		
Stationery, printing, and postage		
Legal expenses		
Interest on mortgages or loans payable		
Taxes		
Miscellaneous		
Total corporation expenses		
Current expenses from special funds for stated purposes: (Show expenditure from each fund separately)		
Grand total current expenses		
Excess of current revenue over current expenses		
Total		

SCHEDULE II

DETAILED STATEMENT OF CURRENT REVENUE

HOSPITAL RECEIPTS (OR OPERATING RECEIPTS)

	1906	1905
Private room patients		
Board of friends of patients		
Ward pay patients		
Special nursing		
Dispensary		
Emergency ward		
Ambulance fees		
Miscellaneous		
Total hospital receipts		
OTHER REVENUE OR INCOME		
From the public treasury		
Donations from individuals to meet current expenses		
Donations from churches to meet current expenses		
From Hospital Saturday and Sunday Association		
Net receipts from entertainments, fairs, fêtes, etc.		
Legacies, unrestricted		
Profits on investments sold		
Revenue from investments or funds for current use		
Miscellaneous		
Total other revenue or income		

SCHEDULE II—*Continued*

	1906	1905
Income from special funds for current expenses: (Show income account each fund separately)		
Grand total current revenue		
Excess current expenses over current revenue		
Total		

SCHEDULE III

SUMMARY OF FINANCIAL TRANSACTIONS FOR THE YEAR ENDED SEPTEMBER 30, 1906

CAPITAL EXPENDITURES

	1906	1905
Additions to sites and grounds		
Additions and betterments, buildings		
Furniture and fixtures (if charged to capital account)		
New machinery (if charged to capital account)		
Apparatus and instruments (if charged to capital account)		
Ambulances, live stock, etc. (if charged to capital account)		
Miscellaneous		
Total capital expenditures		

SURPLUS ACCOUNT

Grand total current expenses, Schedule I		
Loss and depreciation (Show items separately if desired)		
Total		
Surplus for the year		
Total		

SUMMARY OF FINANCIAL TRANSACTIONS FOR YEAR ENDED SEPTEMBER 30, 1906

CAPITAL RECEIPTS

Fully endowed beds		
Partly endowed beds		
General or special funds or gifts for other than current expenses		
(Show receipts account each fund or gift separately)		
Total capital receipts		

DEFICIT ACCOUNT

Grand total current revenue, Schedule II		
Amount charged off endowed bed fund or other fund reserves account liability of hospital having ceased		
Total		
Deficit for the year		
Total		

SCHEDULE IV

COMPARATIVE BALANCE SHEET FOR YEARS ENDED SEPTEMPER 30, 1906 AND 1905

CAPITAL ASSETS

	1906	1905	Increase	Decrease
Hospital properties and equipments:				
Sites and grounds				
Buildings				
Furniture and fixtures				
Machinery and tools				
Apparatus and instruments				
Ambulances, live stock, etc				
Miscellaneous				
Investments:				
Mortgages receivable				
Bonds				
Stocks				
Other investments				
Total capital assets				

CURRENT ASSETS

Loans and notes receivable				
Accounts receivable				
Accounts receivable from public treasury				
General material on hand				
Cash in hands of treasurer				
Cash in hands of superintendent				
Advances:				
Prepaid insurance				
Other prepaid expenses				
Total current assets				
Grand total assets				
Deficit				
Total				

COMPARATIVE BALANCE SHEET FOR YEARS ENDED SEPTEMBFR 30, 1906 AND 1905

CAPITAL LIABILITIES

Capital account (hospital properties and equipments)				
Endowed bed fund reserves				
Partly endowed bed fund reserves				
Other fund reserves (List each separately)				
Bonds, outstanding on hospital property				
Mortgages payable				
Total capital liabilities				

CURRENT LIABILITIES

Loans and notes payable				
Audited vouchers unpaid or accounts payable				
Total current liabilities				
Grand total liabilities				
Surplus				
Total				

SCHEDULE V

STATEMENT SHOWING INCREASE OR DECREASE OF PRINCIPAL OF ALL CAPITAL FUNDS DURING YEAR ENDED SEPTEMBER 30, 1906

Description of Funds	Amount Sept. 30, 1905	Received during Year	Expended during Year	Amount Sept. 30, 1906	Increase	Decrease
TOTAL						

SCHEDULE VI

COMPARATIVE STATISTICS FOR YEARS ENDED SEPTEMBER 30, 1906 AND 1905

HOSPITAL WARDS AND PRIVATE ROOMS

		1906		1805	
Patients in hospital first of year:					
In medical wards:	Male.....	.....		.....	
	Female.....	.....		.....	
In surgical wards:	Male.....	.....	.....	.....	.....
	Female.....	.....		.....	
In private rooms:	Male.....	.....		.....	
	Female.....	.....	.....	.....	.....
Total.....			.....		.....
Patients admitted during year:					
To medical wards:	Male.....	.....		.....	
	Female.....	.....	.....	.....	.....
To surgical wards:	Male.....	.....		.....	
	Female.....	.....	.....	.....	.....
To private rooms:	Male.....	.....		.....	
	Female.....	.....	.....	.....	.....
Total.....		.....	.....	.....	.....

SCHEDULE VI—*Continued*

	1906		1905	
Total patients treated in hospital wards and private rooms during year:				
Male				
Female				
Patients discharged during year:				
Cured				
Improved				
Unimproved				
Transferred to other institutions				
Died				
Total				
Patients in hospital end of year:				
In medical wards: Male				
Female				
In surgical wards: Male				
Female				
In private rooms: Male				
Female				
Total				
Total patient days treatment:				
Free ward				
Endowed bed				
Pay ward				
Private room				
Total				
Percentage				
Free ward days				
Endowed bed days				
Pay ward days				
Private room days				
Average patients per day:				
Free ward				
Endowed bed				
Pay ward				
Private room				
Total				
Average time per patient in hospital				
Daily average cost per private room patient				
Daily average cost per ward patient				

EMERGENCY WARD

Patients under treatment first of year: Male				
Female				
Patients admitted during year: Male				
Female				
Total patients treated during year: Male				
Female				
Patients discharged during year:				
Patients under treatment end of year: Male				
Female				
Visits made to emergency ward during year				
Average visits made per day				
Average visits per patient				
Daily average cost per emergency ward patient				

SCHEDULE VI—*Continued*

		1906		1905	
DISPENSARY					
Patients under treatment first of year:	Male....	.....		.....	
	Female..	.....	.....	.....	.....
Patients admitted during year:	Male....	.....		.....	
	Female..	.....	.....	.....	.....
Total patients treated during year:	Male....	.....		.....	
	Female..	.....	.....	.....	.....
Patients discharged during year			.....		.....
Patients under treatment end of year:	Male....	.....		.....	
	Female..	.....	.....	.....	.....
Visits made to dispensary during year			.....		.....
Average visits per day			.....		.....
Average visits per patient			.....		.....
Daily average cost per dispensary patient			.....		.....
AMBULANCE					
Ambulance calls during year			.....		.....
Average calls per day			.....		.....
Average cost per ambulance call			.....		.....
Patients treated by ambulance surgeon in emergency ward and transferred			.....		.....
Patients treated by ambulance surgeon and left at place of call or transferred direct to other institutions			.....		.....
VISITING OF HOME (DISTRICT) NURSING					
Number of patients visited			.....		.....
Number of visits made			.....		.....
Average visits per day			.....		.....
Average cost per visit			.....		.....
SUMMARY					
Total patients treated during year in all departments			.....		.....
Average patients per day in all departments			.....		.....
Daily average number of employees boarded in hospital			.....		.....
Daily cost per capita for provisions for all persons supported			.....		.....